STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Subcommittee:

On behalf of over 1.2 million members of the Disabled American Veterans (DAV) and its Women's Auxiliary, we are grateful for the opportunity to provide our views on two pieces of legislation affecting our members.

One of the Department of Veterans Affairs' (VA's) primary missions is the provision of health care to our nation's sick and disabled veterans. The Veterans Health Administration (VHA) is the nation's largest direct provider of health care services. Starting less than a decade ago, VA's delivery of health care to veterans began to change from an inpatient-oriented approach to an outpatient model with more than 1,300 access sites in veterans' communities across the United States. To continue improving access for eligible veterans to VA's high quality medical care, we are considering two bills on today's agenda, H.R. 2379, the Rural Veterans Access to Care Act of 2003, and H.R. 3094, the Veterans Timely Access to Health Care Act.

H.R. 2379

The purpose of H.R. 2379 is to improve access to VA health care for highly rural or geographically remote veterans. This legislation would require VA to prescribe regulations to define highly rural or geographically remote veterans, and to include in the definition veterans with driving times of 60 minutes or greater to reach a VA health care facility. This bill would also require VA to ensure funds of not less than 5 percent of its Medical Care account be made available to improve access to care for veterans in highly rural or geographically remote areas through contract for care and other authorities. In addition, unused funds from any service region may be reallocated where needed solely for the treatment of highly rural or geographically remote veterans. After the end of the third fiscal year, the VA would be required to review the operation and to make adjustments to the percentage in effect nationally or by geographic region through recommendation to Congress.

H.R. 3094

The goal of H.R. 3094 is to provide timely access to VA health care. To accomplish this, VA is required to prescribe and periodically review for an annual report to the Committees on Veterans' Affairs of the Senate and House of Representatives standards of time to access medical

care. The time to access medical care is to be determined from the date a veteran contacts VA for an appointment to the date the visit to the provider is completed. Further, this bill prescribes 30 days as the standard for access to a primary care provider. VA would also be required to determine over the first quarter of the first calendar year after enactment of this measure a compliance rate for each Veterans Integrated Service Network.

This bill authorizes VA to furnish health care and services in a non-Department facility to any eligible veteran for which VA is unable to meet the standards for access to care in a VISN with a compliance rate less than 90 percent. With respect to Priority Group 8 veterans, VA may furnish health care and services in a non-Department facility under its discretion. Payment for such care may not exceed the reimbursement rate paid under Part B of the Medicare program, and the non-Department facility may not bill the veteran for any difference between the facility's charges and the amount paid by VA. In addition, VA would be required to submit to the House and Senate Committees on Veterans' Affairs a comprehensive report for each calendar year with respect to waiting times.

DAV agrees that veterans must have access to timely health care and that VA must be held accountable for meeting its own access standards. We have often stated that through their extraordinary sacrifices and contributions, veterans have *earned* the right to free health care as a continuing cost of national defense. We adamantly believe America's citizens, as beneficiaries of veterans' service and sacrifice, want the government to fully honor its moral obligation to provide quality and timely health care services to wartime service-connected disabled veterans.

In so far as H.R. 2379 considers timely access for veterans based on their geographic location in relation to a VA health care facility, careful consideration must be given to its impact on the CARES process. This nationwide initiative is designed to align VA's capital assets to ensure that veterans' future needs for accessible, quality health care are met. Like H.R. 2379, the CARES initiative seeks to address access to care through standards of access, such as specific travel times of urban, rural, and highly rural veterans to the nearest VHA facility.

The wait list for veterans seeking medical care and VA's decision to stop enrollment for new Priority Group 8 veterans this year confirms that the level of resources is not sufficient to continue open enrollment. DAV is concerned about the setting aside of funds from VA's Medical Care account to provide highly rural or geographically remote veterans improved access to VA health care because it could have a negative impact on access to care by other veterans and exacerbate this tenuous situation.

With regards to H.R. 3094, the language pertaining to the amount VA would pay for outpatient services provided by a non-Department facility or provider is not clear. Specifically, if VA's reimbursement rate under Part B of the Medicare program refers to the full fee schedule or 80 percent of the fee schedule amount for which Medicare pays for physicians' services after the beneficiaries have met the annual Part B deductible. It is important to note that participating physicians can only receive equitable compensation of services rendered by billing Medicare beneficiaries the remaining 20 percent of the fee schedule, plus any deductible, commonly referred to as coinsurance.

Certainly, we agree no veteran should be billed for any health care services furnished by VA. Under this measure, however, if a non-Department facility or provider will receive the 80 percent of the fee schedule amount for which Medicare pays for a particular service, and they are not allowed to bill the veteran for any difference between the facility's billed charges and the amount paid by VA, then, we believe this may act as a disincentive for non-Department facilities to accept and treat veterans.

Furthermore, we are deeply concerned that the initiative in both bills to contract care in order to meet access standards would shift medical services and veteran patients from VA to the private sector. The proposal to contract care to non-Department facilities and providers would encourage VA to refer patients, and the dollars used to subsidize their care outside a system specifically created for veterans and their health care needs. This proposal sets a dangerous precedent that, if allowed to expand, could endanger VA facilities' ability to maintain their full range of specialized inpatient services for all veterans. It would erode VHA's patient resource base, undermining VHA's ability to maintain its specialized service programs, and endanger the well being of veteran patients.

To provide timely access to care, we must identify and immediately correct the underlying problems and not the symptoms. We do not oppose other initiatives assisting veterans who reside in underserved areas. We are, however, opposed to any initiative that would turn VA into an insurer rather than a provider of health care. We feel VA must use its resources to maintain the base of its health care services, which are provided through and by VA health care facilities and health care providers. This traditional form of VA health care has served well to the benefit of all veterans to offer an uninterrupted flow of services to veterans in need, and ensure the quality of those services no matter where or when they are provided.

Due to insufficient funding, VA is struggling to provide timely health care to all veterans seeking care. We believe that VA must have guaranteed full funding for all priority groups to meet the requirements of any standard for access to care. This Subcommittee is well aware of the funding crisis VA health care is facing and its impact on sick and disabled veterans who depend on VA's specialized programs and services. In the years since open enrollment, VA has been forced to do more with less. Even though over the past two budget cycles, Congress has increased discretionary appropriations for veterans' health care, the funding levels have simply not kept pace with inflation and the significant increase in demand for services.

If given proper funding, VA should be held accountable for meeting demand in a timely manner and only as a last resort would we want care to be contracted out. Moreover, if VA receives sufficient appropriation, it should be able to plan for the appropriate number of staff necessary to provide veterans care within VA facilities in a cost-effective manner.

In closing, DAV thanks this Subcommittee for holding this hearing and for its interest in improving benefits and services for our Nation's disabled veterans. The DAV deeply values the advocacy this Subcommittee has always demonstrated on behalf of America's service-connected disabled veterans and their families. We sincerely appreciate the opportunity to present our views on these important measures.